

<b>Case Number:</b>	CM15-0184011		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	09/04/2013
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 49 year old male who sustained an industrial injury on 09/04/2013. Medical records indicated the worker was treated for sacroiliitis, depression, loss of bladder control, chronic pain due to trauma, chronic lumbago, spasm of muscle, myalgia and myositis unspecified, degeneration of lumbar or lumbosacral intervertebral disc and incontinence of feces. In the provider notes of 08-24-2015, the worker complained of moderate back pain and back spasms in the low back. He states he has no control over his urination and his bowel movements. Treatment has included thermacare, transcutaneous electrical nerve stimulation (TENS) unit, physical therapy, and chiropractic care. On 08-10-2015, the worker received a sacroiliac joint injection bilaterally with fluoroscopy. His pre-procedure pain score was 8 on a scale of 0-10, and his post procedure pain score was 0 on a scale of 0-10. Continued treatments included medical marijuana 1-2 joints per day, Thermacare patches, one per day, and doxepin 10 mg taken 2 80 minutes before. A request for authorization was submitted 09-04-2015 for: 1. Thermacare patches #8. 2. Doxepin HCL 10mg with 1 refill. 3. Physical therapy 2 times a week for 6 weeks for pelvic floor exercises. A utilization review decision 09/04/2015 non-certified all of the requests.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

### **Thermacare patches #8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Cold/heat packs.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

**Decision rationale:** American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Page 48 of ACOEM, under Initial Approach to Treatment notes: This claimant was injured in 2013 and had diagnoses of sacroiliitis, depression, loss of bowel and bladder control, back pain and spasm. ThermaCare provides chemically generated heat. However, the MTUS/ACOEM guides note that "during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day." More elaborate heat administration, such as ThermaCare pads simply not needed to administer heat modalities; the guides note it is something a claimant can do at home with simple home hot packs. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request was not medically necessary.

### **Doxepin HCL 10mg with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, under Antidepressants.

**Decision rationale:** This claimant was injured in 2013 and had diagnoses of sacroiliitis, depression, loss of bowel and bladder control, back pain and spasm. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is not medically necessary.

**Physical therapy 2 times a week for 6 weeks for pelvic floor exercises: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** This claimant was injured in 2013 and had diagnoses of sacroiliitis, depression, loss of bowel and bladder control, back pain and spasm. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. In addition, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization. This request for more skilled, monitored therapy was not medically necessary.